STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	390256	A. BLDG: 00 B. WING:	06/26/2017

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: **135101**	**500 UNIVERSITY DRIVE** **P.O. BOX 850** **HERSHEY, PA 17033**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
A 0000	INITIAL COMMENT	A 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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A 0000	Continued from page 1 This report is the result of an unannounced complaint investigation (HBG17I180H) conducted on-site April 12-13, 2017, at Milton S Hershey Medical Center. It was determined that the facility was not in compliance with the requirements of 42 CFR, Title 42, Part 482-Conditions of Participation for Hospitals. Immediate Jeopardy was called on April 13, 2017, at 10:40 AM for failing to monitor the temperature of a patient using a Bair Hugger. The facility submitted an action plan on April 13, 2017, at 5:00 PM to address the immediate jeopardy situation. The plan was returned to the facility so that the facility could add additional information. The facility re-submitted an action plan on April 13, 2017 at 7:29 PM to address the immediate jeopardy situation. The facility's immediate action plan included staff	A 0000		

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A 0000	Continued from page 2 education, counseling, policy change, new evaluation process, audits, and competency process change The Immediate Jeopardy was abated on April 13, 2017 at 7:29 PM.	A 0000		
A 0020		A 0020		

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A 0020	Continued from page 3 482.11 COMPLIANCE WITH LAWS Compliance with Federal, State and Local Laws This REQUIREMENT is not met as evidenced by:	A 0020	1. The Penn State Health Milton Hershey Medical Center (HMC) Chief Medical Officer (CMO) and Chief Quality Officer (CQO), shall email all direct care physicians and advanced practice clinicians a memo regarding this serious patient safety event with reminders about requirements on reporting patient safety events in the patient safety event reporting system. This was completed on April 15, 2017. 2. The HMC Patient Safety Officer (PSO) will institute an electronic health record hard stop alert (an alert that will be triggered when any direct care staff log onto the electronic health record, precluding that staff member from proceeding without acknowledging receipt and review of the alert) indicating the changes to the relevant standards of care and requiring active acknowledgement by the staff member of the message regarding event reporting requirements. An initial compliance report will be generated demonstrating acknowledgement of	Completion Date: **07/24/2017** Status: **APPROVED** Date: **07/14/2017**

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A 0020	Continued from page 4	A 0020	this alert within 30 days by direct care staff employed at the time of survey. The electronic health record hard stop alert will remain in effect for four months for all direct care staff that access the electronic health record system for the first time after April 14, 2017. This was initiated on April 14, 2017. This reporting requirement message will be sustained in new employee orientation and annual safety training in the fiscal year 2018 curriculum. 3. The HMC Chief Nursing Officer will email all nursing staff information regarding this serious patient safety event with reminders about requirements on reporting patient safety events in the patient safety event reporting system. This was completed on April 13, 2017. 4. The PSO will read the HMC CMO and CQO memo regarding this serious patient safety event with reminders about requirements on reporting patient safety events in the	

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A 0020	Continued from page 5	A 0020	patient safety event reporting system at the Daily Safety Briefing. This was announced on April 14, 2017, at 11am. 5. The PSO will oversee the individual counseling and review of the patient safety event reporting for the involved eight clinicians. An attendance roster for the education sessions will document and be attached to the patient safety event report file. All counseling was completed and documented by April 21, 2017 briefing. 6. In order to educate all HMC employees, the PSO will assign to all HMC employees a required Compass learning course (HMC's internal electronic staff education platform) to be completed within 30 days, with content describing timely reporting of patient safety events, HMC expectations of Patient Safety Event Reporting, the methods to report, and references to the Patient Safety Event Reporting policy A09 HAM. Course completion will be tracked in	

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A 0020	Continued from page 6	A 0020	the Compass electronic system. Failure to complete this required course will result in the application of the Progressive Discipline Policy. The training was made available on April 21, 2017. 7. A new Patient Safety departmental policy will be implemented by July 17, 2017 to clearly outline timelines for event reporting into PA-PSRS containing key steps to ensure timely reporting. Escalation to the PSO will occur for delays in review and investigation. The investigation and overall review of events along with an initial consideration for PA-PSRS designation will occur no later than 14 days of initiating the review. Reasons for extension beyond 14 days will be documented in our internal event reporting system by the PSO. After 14 days, if questions still exist regarding the event designation but the event is considered at least an "Incident," the event will be entered into PA-PSRS as an "Incident" until	

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A 0020	Continued from page 7	A 0020	further confirmation occurs. Any time during the 14 day internal review, if an event is confirmed, the report will be entered into the PA-PSRS portal within 24 hours as per current policy. This process will ensure the report is routed appropriately to the Pennsylvania DOH and/or the PA Patient Safety Authority as applicable. This policy will be implemented July 17, 2017. 8. The PSO and CQO will monitor for compliance with regard to timely PA-PSRS reporting and make available, monthly, a report outlining timespans between event date, internal reporting date, and PA-PSRS reporting date to the Patient Safety Committee. This reporting will begin on July 24, 2017. 9. We will continue engagement with our patient safety organization (ECRI) to assist in providing institutional resources, including staff education, that will promote a culture of safety. Additionally, we contracted with Healthcare	

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A 0020	Continued from page 8	A 0020	Performance Improvement (HPI) to provide patient safety-related content, and to assist in a comprehensive assessment of our current culture of safety and develop a road map for improvement. Staff education with materials derived from HPI began on June 15, 2017.	

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A 0020	Continued from page 9 Based on review of facility documents, medical records (MR), Department of Health's (Department) database, and staff interview (EMP), it was determined the facility failed to conform to all State laws: Milton S Hershey Medical Center was not in compliance with the following State law: The Medical Care Availability and Reduction of Error Act, 40 P.S. § 1303.101 et seq. § 1303.313 Medical Facility reports and notifications (a) Serious event reports A medical facility shall report the occurrence of a serious event to the department and the authority within 24 hours of the medical facility's confirmation of the occurrence of the serious event. The report to the department and the authority shall be in the form and manner prescribed by the authority in consultation with the department and shall not include the name of any patient or any other identifiable individual information. (b) Incident reports A medical facility shall report the	A 0020		

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A 0020	Continued from page 10 occurrence of an incident to the authority in a form and manner prescribed by the authority and shall not include the name of any patient or any other individual information. (c) Infrastructure failure reports. A medical facility shall report the occurrence of an infrastructure failure to the department within 24 hours of the medical facility's confirmation of the occurrence or discovery of the infrastructure failure. The report to the department shall be in the form and manner prescribed by the department. This is not met as evidenced by: Based on review of facility documents, medical records (MR), Department of Health's (Department) database, and staff interview (EMP), it was determined the facility failed to report a serious event to the Department and the Patient Safety Authority within 24 hours of the occurrence. Findings include:	A 0020		

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MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101	500 UNIVERSITY DRIVE P.O. BOX 850 HERSHEY, PA 17033

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A 0020	Continued from page 11 A review on April 13, 2017, of the facility's "Performance Improvement Plan," effective June 2016, revealed "...External reporting...Serious events and infrastructure failures will be reported to the DOH within 24 hours of confirmation of occurrence via the Pennsylvania Patient Safety Reporting System. Serious Events will be reported to the Patient Safety Authority within 24 hours of confirmation of occurrence via the Pennsylvania Patient Safety Reporting System. ..." A review on April 12-13, 2017, of MR1 revealed the patient arrived in the Emergency Department on January 10, 2017, at 2:51 PM, with a temperature of 89.4 degrees F, rectally. A Bair Hugger (blanket warmer device) was applied to the patient. The following patient temperatures were obtained rectally: 90.8 F at 8:16 PM, 92.8 F at 9:14 PM, 97.8 at 10:44 PM, and 98.0 F at 12:14 AM on January 11, 2017. There were no other temperatures documented until 10:22 AM on January 11, 2017. The patient's rectal temperature at that time was 107.6 F. A review of physician	A 0020		

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A 0020	Continued from page 12 inpatient note addendum dated January 13, 2017, revealed "...We came and saw him in ED around 10 AM. There were no vitals and his last temp was around midnight. The nurse during the rounds told us him temp was now 42 C {107.6 F}. We asked about the Bair Hugger and it had been on high all night. ..." The patient was transferred to pediatric intensive care unit (PICU). A review of the discharge summary, revealed, the patient "...arrived to the PICU in shock with ECG changes consisting of QRS widening and ST elevation, worrisome for conduction system impairment in addition to myocardial functional impairment. ...Despite all these measures, QRS degenerated, there are episodes of pulseless ventricular tachycardia superimposed on a baseline of persistent hypotension. ...Hypotension persisted, with chaotic QRS morhphology and unstable hemodynamics despite ongoing resuscitative efforts. He expired at 5:39 PM." A review of the Department's database revealed the facility reported the above incident on March 29, 2017, to the Pennsylvania State Reporting	A 0020		

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A 0020	Continued from page 13 System (PSRS), 77 days after the event. An interview conducted on April 12, 2017, at 11:45 AM with EMP9 confirmed the facility did not report the event until March 29, 2017. EMP9 stated the facility became aware after the Patient Safety Authority sent the facility a letter dated March 3, 2017, regarding the event. EMP9 stated that an employee reported the event anonymously to the Patient Safety Authority. EMP9 confirmed that no one from the facility had entered the event into the facilty's internal reporting system. EMP9 stated that he would have expected multiple reports regarding this event. EMP9 further stated that "Hands down, no questions, it should have been reported right away."	A 0020		
A 0395		A 0395		

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A 0395	Continued from page 14 482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This REQUIREMENT is not met as evidenced by:	A 0395	1. The Penn State Health Milton S. Hershey Medical Center (HMC) Emergency Department (ED) Nurse Manager will discuss with the involved registered nurses (RNs), the need to document all vital signs (temperature, heart rate,pulse, blood pressure and oxygen saturation) as required in Emergency Department Nursing Standard of Care E 8CPMN (revision date April 13, 2017). The Emergency Department Nursing Standard of Care E 8CPMN was revised on April 13, 2017. The involved RN communication was completed on April 14, 2017. The involved RNs acknowledged in writing that they will comply with required vital sign documentation. Documentation was provided demonstrating that each RN reviewed and agreed to an understanding of this revised standard of care on April 14, 2017. 2. The ED Nurse Manager shall communicate via email to all ED nursing staff the revised standard of care E 8CPMN. The ED nursing staff	Completion Date: **04/17/2017** Status: **APPROVED** Date: **07/11/2017**

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A 0395	Continued from page 15	A 0395	will be required to acknowledge their review of the standard of care with their signature captured on a roster. This email was sent on April 13, 2017. 3. The ED Nurse Manager will review the expectations for vital sign documentation in a weekly newsletter that is distributed to ED staff. The newsletter was emailed on April 14, 2017. 4. For a period of three months, the ED Nurse Manager will oversee audits of thirty (30) randomly selected ED medical records per month for appropriate documentation of vital signs as per the revised standard of care E 8CPMN. These monthly audits will include the involved RNs in each monthly audit. The name of the ED nurse who documented vitals in those records will be recorded for audit tracking purposes. This audit process was initiated on April 17, 2017. 5. The ED Nurse Manager will monitor audit results and utilize the Progressive Discipline process to	

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A 0395	Continued from page 16	A 0395	address any findings of noncompliance as needed with identified staff RNs.	

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A 0395	Continued from page 17 Based on review of facility policy, medical record (MR) and staff interview (EMP), it was determined the facility failed to evaluate the nursing care for one of 11 medical records reviewed (MR1). Findings include: A review of facility policy "Children's Hospital Standard of Care" effective December 2016, revealed, "...f. Ongoing patient assessment includes the following: Vital Signs...Temperature...For heating/cooling devices: Minimum of every 2 hours when a patient is under a heating lamp, warming blanket, or cooling blanket. If not contraindicated, patients requiring warming/cooling blanket should have continuous temperature monitoring rectal or foley probe in place...." A review on April 12-13, 2017, of MR1 revealed the patient arrived in the Emergency Department on January 10, 2017, at 2:51 PM, with a temperature of 89.4 degrees F, rectally. A Bair Hugger (blanket warmer device) was applied to the patient. The	A 0395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	390256	A. BLDG: 00 B. WING:	06/26/2017

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A 0395	Continued from page 18 following patient temperatures were obtained rectally: 90.8 F at 8:16 PM, 92.8 F at 9:14 PM, 97.8 at 10:44 PM, and 98.0 F at 12:14 AM on January 11, 2017. There were no other temperatures documented until 10:22 AM on January 11, 2017. The patient's rectal temperature at that time was 107.6 F. A review of physician inpatient note addendum dated January 13, 2017, revealed "...We came and saw him in ED around 10 AM. There were no vitals and his last temp was around midnight. The nurse during the rounds told us him temp was now 42 C {107.6 F}. We asked about the bair hugger and it had been on high all night. ..." An interview conducted on April 13, 2017, at 9:40 AM with EMP19 confirmed that the temperatures were not documented in the patient's medical record. EMP19 stated "I know I took temps. I was in the room every hour doing eye drops. I must have not documented, I did not have the computer with me. I was probably busy with something else."	A 0395		

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A 0395	Continued from page 19 An interview conducted on April 12, 2017, at 10:45 AM with EMP4 confirmed that no temps were documented for a "10 hour period."	A 0395		
A 0397		A 0397		

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A 0397	Continued from page 20 482.23(b)(5) PATIENT CARE ASSIGNMENTS A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. This REQUIREMENT is not met as evidenced by:	A 0397	1. The Penn State Health Milton S. Hershey Medical Center (HMC) Emergency Department (ED) Nurse Manager shall discuss the requirements to complete all ED nursing competency checklists with the involved agency registered nurse (RN). This discussion occurred with the involved agency RN and the competency checklists were completed on April 15, 2017. 2. HMC shall formalize the process to on-board and track all agency RN general and departmental orientation checklists, which will include competencies. The agency RN will be required to complete these competency checklists within 2 weeks of his or her start date. Completed competency checklists will be reviewed and signed by the Clinical Nurse Educator/designee and/or Nurse Manager/designee to signify approval and completion of the agency nurse's orientation. This new process was initiated on April 17, 2017. If an agency nurse's completed competency checklist is not received within 2 weeks of his or	Completion Date: **07/17/2017** Status: **APPROVED** Date: **07/14/2017**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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A 0397	Continued from page 21	A 0397	her start date, that agency nurse will be placed back on orientation on the next scheduled shift and continue on orientation until the checklists are completed and turned into the Clinical Nurse Educator/designee and Nurse Manager/designee. This process will be implemented July 17, 2017. 3. The Nurse Manager of the Float Pool/designee reviewed all agency nurse files for any incomplete items on all HMC Core Competency checklists. If any incomplete competency items were noted, the departmental Nurse Educators/designee assisted these nurses in completing these items. The agency RNs were given one week to complete the checklist. This review was completed on April 17, 2017. 4. For any incomplete checklist items that were identified, the Nurse Manager of the Float Pool/designee contacted individual Nurse Managers and Clinical Nurse Educators to ensure the agency RN completed the missing checklist	

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A 0397	Continued from page 22	A 0397	items within a one week period. The Nurse Managers and Clinical Nurse Educators were contacted, and the completed checklist items were received by the Nurse Manager of the Float Pool by April 21, 2017. 5. The Nurse Manager of S&SD shall educate all of the Nurse Managers, including those not currently utilizing agency nursing staff, on the agency personnel process. This process shall include the agency nurse competency evaluation. Information on the agency personnel process was presented to the Nurse Managers at the Clinical Services Management Council on May 18, 2017.	

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A 0397	Continued from page 23 Based on review of facility documents, personnel file (PF), and staff interview (EMP), it was determined that the facility failed to ensure that the employee received orientation/training on the thermoregulation technique and devices for one of three personnel files reviewed (PF3). Findings include: A review of facility Emergency Department Registered Nurse Core Competency on April 12, 2017, revealed "...Integumentary/Surface Trauma Competency Statement: Demonstrate or verbalized an ability to assess, identify, provide care, manage, and troubleshoot potential or actual life-threatening integumentary/surface trauma emergencies and associated equipment. ...4. Thermoregulation techniques & devices - cooling machine/Bear {sic} hugger." Further review of the competency form revealed, "This form is to be completed within the allotted hours for orientation at PSHMC."	A 0397		

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A 0397	Continued from page 24 A review of PF3 on April 12, 2017, revealed the Emergency Department Registered Nurse Core Competency was not complete. The Thermoregulation techniques & devices - cooling machine/Bear {sic} hugger was not signed off as completed. Further review of PF3 revealed the employee was hired on April 19, 2016. An interview conducted on April 13, 2017, at 9:30 AM with EMP4 confirmed the nurse core competency was not completed for thermoregulation techniques & devices - cooling machine/Bair Hugger for PF3 and that the employee was hired one year ago.	A 0397		
A 0398		A 0398		

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A 0398	Continued from page 25 482.23(b)(6) SUPERVISION OF CONTRACT STAFF Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This REQUIREMENT is not met as evidenced by:	A 0398	1. The Penn State Health Milton S. Hershey Medical Center (HMC) Manager of Scheduling & Staff Deployment (S&SD) shall create a new process for agency nurse evaluations. The Manager of S&SD will create an evaluation tracking log for all agency nurses to be reviewed weekly by the Manager of S&SD or designee. The tracking log will include the name of the agency nurse and the completion date of the evaluation. The agency will also notify the Manager of S&SD that an evaluation is due for the agency nurse six weeks after the nurse's start date. This process for agency nurse evaluations, including the tracking log was initiated on April 14, 2017. The new process was reviewed by the Manager of S&SD, with all nurse managers utilizing agency nursing staff. 2. A new process shall be created to ensure complete agency nurse evaluations. When an agency nurse's six-week evaluation is due, the Manager of S&SD will send an	Completion Date: **07/17/2017** Status: **APPROVED** Date: **07/14/2017**

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A 0398	Continued from page 26	A 0398	electronic communication to the relevant Nurse Manager with a link to the online agency nurse evaluation form. The Nurse Manager shall complete the electronic evaluation within three business days of receipt and respond to the Manager of S&SD that the evaluation has been completed. The Manager of S&SD will ensure that the evaluations are completed by the Nurse Manager within three business days. The Manager of S&SD will then mark the evaluation completed in the evaluation tracking log. This process was initiated on April 14, 2017. If the agency nurse evaluation is not completed within three business days, the Manager of S&SD will notify the Director of Nursing to take action. If issues are identified, actions may include the progressive discipline process, in order to obtain evaluation. This will be implemented on July 17, 2017. 3. The HMC Nurse Managers and the Agency Supervisors will monitor for known performance issues and	

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A 0398	Continued from page 27	A 0398	inform the Manager of S&SD or designee, as appropriate. The Manager of S&SD or designee will investigate and validate any issues with the relevant Nurse Manager. Based on the findings of the investigation, the Manager of S&SD will decide whether to remediate or terminate the agency nurse's contract. This process was implemented on April 14, 2017. 4. The Nurse Manager of S&SD shall educate all of the Nurse Managers, including those not currently utilizing agency nursing staff, on the agency personnel process. This process shall include the agency nurse evaluation. This information was presented to the Nurse Managers at the Clinical Services Management Council on May 18, 2017.	

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A 0398	Continued from page 28 Based on review of facility policy, personnel files (PF), and staff interview (EMP), it was determined the facility failed to ensure periodic work performance evaluations were completed for one of three personnel files reviewed (PF1). Findings include: A review of facility policy "Agency Personnel" effective October 2015, revealed, "...b. {name redacted} Healthcare will send an evaluation form, six weeks after the agency personnel has worked on the unit. Evaluation form will be completed electronically by the Nurse Manager or designee and submitted to {name redacted} Healthcare. Evaluation is kept on file by {name redacted} Healthcare. ..." A review of PF3 on April 12, 2017, revealed the employee was hired on April 19, 2016. There were no evaluations in the personnel file.	A 0398		

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A 0398	Continued from page 29 An interview conducted April 13, 2017, at 9:20 AM with EMP18 confirmed that no evaluations were done for PF3. EMP18 further confirmed that the facility should have done 3 evaluations, at least 6 weeks apart, for PF3.	A 0398		
A 0438		A 0438		

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A 0438	Continued from page 30 482.24(b) FORM AND RETENTION OF RECORDS The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. This REQUIREMENT is not met as evidenced by:	A 0438	1. The Penn State Health Milton S. Hershey Medical Center (HMC) Emergency Department (ED) Nurse Manager will discuss with the involved registered nurses (RNs), the need to document all vital signs (temperature, heart rate, pulse, blood pressure and oxygen saturation) as required in Emergency Department Nursing Standard of Care E 8CPMN (revision date: April 13, 2017). The Emergency Department Nursing Standard of Care E 8CPMN was revised on April 13, 2017. The involved RN communication was completed on April 14, 2017. The involved RNs acknowledged in writing that they will comply with required vital sign documentation. Documentation was provided demonstrating that each RN reviewed and agreed to an understanding of this revised standard of care on April 14, 2017. 2. The ED Nurse Manager shall communicate via email to all ED nursing staff the revised standard of care E 8CPMN. The ED nursing staff	Completion Date: **04/17/2017** Status: **APPROVED** Date: **07/11/2017**

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A 0438	Continued from page 31	A 0438	will be required to acknowledge their review of the standard of care with their signature captured on a roster. This email was sent on April 13, 2017. 3. The ED Nurse Manager will review the expectations for vital sign documentation in a weekly newsletter that is distributed to ED staff. The newsletter was emailed on April 14, 2017. 4. For a period of three months, the ED Nurse Manager will oversee audits of thirty (30) randomly selected ED medical records per month for appropriate documentation of vital signs as per the revised standard of care E 8CPMN. These monthly audits will include the involved RNs in each monthly audit. The name of the ED nurse who documented vitals in those records will be recorded for audit tracking purposes. This audit process was initiated on April 17, 2017.	

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A 0438	Continued from page 32	A 0438	5. The ED Nurse Manager will monitor audit results and utilize the Progressive Discipline process to address any findings of noncompliance as needed with identified staff RNs.	

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A 0438	Continued from page 33 Based on review of facility policy, medical record (MR) and staff interview (EMP), it was determined the facility failed to ensure all clinical information pertaining to a patient shall be completely and accurately incorporated in the medical record for one of 11 medical records reviewed (MR1). Findings include: A review of facility policy "Children's Hospital Standard of Care" effective December 2016, revealed, "...f. Ongoing patient assessment includes the following: Vital Signs...Temperature...For heating/cooling devices: Minimum of every 2 hours when a patient is under a heating lamp, warming blanket, or cooling blanket. If not contraindicated, patients requiring warming/cooling blanket should have continuous temperature monitoring rectal or foley probe in place...." A review on April 12-13, 2017, of MR1 revealed the patient arrived in the Emergency Department on January 10, 2017, at 2:51 PM, with a temperature	A 0438		

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A 0438	Continued from page 34 of 89.4 degrees F, rectally. A Bair Hugger (blanket warmer device) was applied to the patient. The following patient temperatures were obtained rectally: 90.8 F at 8:16 PM, 92.8 F at 9:14 PM, 97.8 at 10:44 PM, and 98.0 F at 12:14 AM on January 11, 2017. There were no other temperatures documented until 10:22 AM on January 11, 2017. The patient's rectal temperature at that time was 107.6 F. A review of physician inpatient note addendum dated January 13, 2017, revealed "...We came and saw him in ED around 10 AM. There were no vitals and his last temp was around midnight. The nurse during the rounds told us him temp was now 42 C {107.6 F}. We asked about the bair hugger and it had been on high all night. ..." An interview conducted on April 13, 2017, at 9:40 AM with EMP19 confirmed that medical record documentation was not complete due to the failure to include the patient's temperatures. EMP19 stated "I know I took temps. I was in the room every hour doing eye drops. I must have not documented, I	A 0438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	390256	A. BLDG: __00_____ B. WING: _____	06/26/2017

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: **135101**	**500 UNIVERSITY DRIVE P.O. BOX 850 HERSHEY, PA 17033**

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A 0438	Continued from page 35 did not have the computer with me. I was probably busy with something else." An interview conducted on April 12, 2017, at 10:45 AM with EMP4 confirmed that no temps were documented for a "10 hour period."	A 0438		
A 0467		A 0467		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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A 0467	Continued from page 36 482.24(c)(4)(vi) CONTENT OF RECORD: ORDERS,NOTES,REPORTS [All records must document the following, as appropriate:] All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition. This REQUIREMENT is not met as evidenced by:	A 0467	1. The Penn State Health Milton S. Hershey Medical Center (HMC) Emergency Department (ED) Nurse Manager will discuss with the involved registered nurses (RNs), the need to document all vital signs (temperature, heart rate, pulse, blood pressure and oxygen saturation) as required in Emergency Department Nursing Standard of Care E 8CPMN (revision date April 13, 2017). The Emergency Department Nursing Standard of Care E 8CPMN was revised on April 13, 2017. The involved RN communication was completed on April 14, 2017. The involved RNs acknowledged in writing that they will comply with required vital sign documentation. Documentation was provided demonstrating that each RN reviewed and agreed to an understanding of this revised standard of care on April 14, 2017. 2. The ED Nurse Manager shall communicate via email to all ED nursing staff the revised standard of care E 8CPMN. The ED nursing staff	Completion Date: **04/17/2017** Status: **APPROVED** Date: **07/11/2017**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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A 0467	Continued from page 37	A 0467	will be required to acknowledge their review of the standard of care with their signature captured on a roster. This email was sent on April 13, 2017. 3. The ED Nurse Manager will review the expectations for vital sign documentation in a weekly newsletter that is distributed to ED staff. The newsletter was emailed on April 14, 2017. 4. For a period of three months, the ED Nurse Manager will oversee audits of thirty (30) randomly selected ED medical records per month for appropriate documentation of vital signs as per the revised standard of care E 8CPMN. These monthly audits will include the involved RNs in each monthly audit. The name of the ED nurse who documented vitals in those records will be recorded for audit tracking purposes. This audit process was initiated on April 17, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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A 0467	Continued from page 38	A 0467	5. The ED Nurse Manager will monitor audit results and utilize the Progressive Discipline process to address any findings of noncompliance as needed with identified staff RNs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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A 0467	Continued from page 39 Based on review of facility policy, medical record (MR) and staff interview (EMP), it was determined the facility failed to ensure clinical information pertaining to the patient's condition was consistently documented in the medical record for one of 11 medical records reviewed (MR1). Findings include: A review of facility policy "Children's Hospital Standard of Care" effective December 2016, revealed, "...f. Ongoing patient assessment includes the following: Vital Signs...Temperature...For heating/cooling devices: Minimum of every 2 hours when a patient is under a heating lamp, warming blanket, or cooling blanket. If not contraindicated, patients requiring warming/cooling blanket should have continuous temperature monitoring rectal or foley probe in place...." A review on April 12-13, 2017, of MR1 revealed the patient arrived in the Emergency Department on January 10, 2017, at 2:51 PM, with a temperature	A 0467		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101	500 UNIVERSITY DRIVE P.O. BOX 850 HERSHEY, PA 17033

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A 0467	Continued from page 40 of 89.4 degrees F, rectally. A Bair Hugger (blanket warmer device) was applied to the patient. The following patient temperatures were obtained rectally: 90.8 F at 8:16 PM, 92.8 F at 9:14 PM, 97.8 at 10:44 PM, and 98.0 F at 12:14 AM on January 11, 2017. There were no other temperatures documented until 10:22 AM on January 11, 2017. The patient's rectal temperature at that time was 107.6 F. A review of physician inpatient note addendum dated January 13, 2017, revealed "...We came and saw him in ED around 10 AM. There were no vitals and his last temp was around midnight. The nurse during the rounds told us him temp was now 42 C {107.6 F}. We asked about the bair hugger and it had been on high all night. ..." An interview conducted on April 13, 2017, at 9:40 AM with EMP19 confirmed that the medical record failed to include documentation of the patient's temperatures. EMP19 stated "I know I took temps. I was in the room every hour doing eye drops. I must have not documented, I did not have the	A 0467		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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A 0467	Continued from page 41 computer with me. I was probably busy with something else." An interview conducted on April 12, 2017, at 10:45 AM with EMP4 confirmed that no temps were documented for a "10 hour period."	A 0467		
A 1100		A 1100		

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A 1100	Continued from page 42 482.55 EMERGENCY SERVICES The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by:	A 1100	1. The Penn State Health Milton S. Hershey Medical Center (HMC) Emergency Department (ED) Nurse Manager will discuss with the involved registered nurses (RNs), the need to document all vital signs (temperature, heart rate, pulse, blood pressure and oxygen saturation) as required in Emergency Department Nursing Standard of Care E 8CPMN (revision date April 13, 2017). The Emergency Department Nursing Standard of Care E 8CPMN was revised on April 13, 2017. The involved RN communication was completed on April 14, 2017. The involved RNs acknowledged in writing that they will comply with required vital sign documentation. Documentation was provided demonstrating that each RN reviewed and agreed to an understanding of this revised standard of care on April 14, 2017. 2. The ED Nurse Manager shall communicate via email to all ED nursing staff the revised standard of care E 8CPMN. The ED nursing staff	Completion Date: **04/17/2017** Status: **APPROVED** Date: **07/11/2017**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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A 1100	Continued from page 43	A 1100	will be required to acknowledge their review of the standard of care with their signature captured on a roster. This email was sent on April 13, 2017. 3. The ED Nurse Manager will review the expectations for vital sign documentation in a weekly newsletter that is distributed to ED staff. The newsletter was emailed on April 14, 2017. 4. For a period of three months, the ED Nurse Manager will oversee audits of thirty (30) randomly selected ED medical records per month for appropriate documentation of vital signs as per the revised standard of care E 8CPMN. These monthly audits will include the involved RNs in each monthly audit. The name of the ED nurse who documented vitals in those records will be recorded for audit tracking purposes. This audit process was initiated on April 17, 2017.	

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A 1100	Continued from page 44	A 1100	5. The ED Nurse Manager will monitor audit results and utilize the Progressive Discipline process to address any findings of noncompliance as needed with identified staff RNs.	

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A 1100	Continued from page 45 Based on review of facility policy, medical record (MR) and staff interview (EMP), it was determined the facility failed to meet the emergency needs of a patient in accordance with acceptable standards of practice for one of 11 medical records reviewed (MR1). Findings include: A review of facility policy "Children's Hospital Standard of Care" effective December 2016, revealed, "...f. Ongoing patient assessment includes the following: Vital Signs...Temperature...For heating/cooling devices: Minimum of every 2 hours when a patient is under a heating lamp, warming blanket, or cooling blanket. If not contraindicated, patients requiring warming/cooling blanket should have continuous temperature monitoring rectal or foley probe in place...." A review on April 12-13, 2017, of MR1 revealed the patient arrived in the Emergency Department on January 10, 2017, at 2:51 PM, with a temperature	A 1100		

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A 1100	Continued from page 46 of 89.4 degrees F, rectally. A Bair Hugger (blanket warmer device) was applied to the patient. The following patient temperatures were obtained rectally: 90.8 F at 8:16 PM, 92.8 F at 9:14 PM, 97.8 at 10:44 PM, and 98.0 F at 12:14 AM on January 11, 2017. There were no other temperatures documented until 10:22 AM on January 11, 2017. The patient's rectal temperature at that time was 107.6 F. A review of physician inpatient note addendum dated January 13, 2017, revealed "...We came and saw him in ED around 10 AM. There were no vitals and his last temp was around midnight. The nurse during the rounds told us him temp was now 42 C {107.6 F}. We asked about the bair hugger and it had been on high all night. ..." An interview conducted on April 13, 2017, at 9:40 AM with EMP19 confirmed that the temperatures were not documented in the medical record. EMP19 stated "I know I took temps. I was in the room every hour doing eye drops. I must have not documented, I did not have the computer with me.	A 1100		

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A 1100	Continued from page 47 I was probably busy with something else." An interview conducted on April 12, 2017, at 10:45 AM with EMP4 confirmed that no temps were documented for a "10 hour period."	A 1100		
A 1104		A 1104		

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A 1104	Continued from page 48 482.55(a)(3) EMERGENCY SERVICES POLICIES [If emergency services are provided at the hospital --] (3) The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff. This REQUIREMENT is not met as evidenced by:	A 1104	1. The HMC Nursing Quality and Safety Program Director will revise the Adult, Children's Hospital, Emergency Department, Peri-anesthesia, and Women's Health standards of care to reflect a consistent temperature monitoring standard for patients being warmed with a warming blanket. The aforementioned standards were revised and on April 13, 2017, they were approved for immediate application. 2. The Nursing Quality and Safety Program Director will facilitate revision of the Adult, Children's Hospital, Emergency Department, and Peri-anesthesia and Women's Health standards of care to be consistent with manufacturer instructions of temperature monitoring every 20 minutes. The revised standards of care shall be communicated to all relevant inpatient nursing and provider staff. The standards were revised on April 13, 2017. The communication to all inpatient nursing and provider staff	Completion Date: **07/05/2017** Status: **APPROVED** Date: **07/14/2017**

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A 1104	Continued from page 49	A 1104	occurred on April 14, 2017. 3. The Nursing Quality and Safety Program Director shall instruct all Nurse Managers to include communication regarding the newly updated standards of care in their next weekly updates to nursing staff. This was accomplished on April 14, 2017. 4. The device-specific policy B-7: BAIR-HUGGER WARMING THERAPY and CABINET BLANKET GUIDELINES (PACU) will be deleted to eliminate the possibility for differing interpretations of the policy and standards of care. This was completed on April 13, 2017. 5. An electronic health record hard stop alert (an alert that will be triggered when any direct care staff log onto the electronic health record, precluding that staff member from proceeding without acknowledging	

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A 1104	Continued from page 50	A 1104	receipt and review of the alert) indicating the changes to the relevant standards of care will be instituted, requiring active acknowledgment for all direct care staff. A compliance report will be generated to demonstrate acknowledgement of this alert within 30 days by direct care staff employed at the time of survey. The electronic health record hard stop alert will remain in effect for four months, for all direct care staff that access the electronic health record system for the first time after April 14, 2017. This was initiated on April 14, 2017. This reporting requirement message will be sustained in new employee orientation and annual safety training in the fiscal year 2018 curriculum. 6. The Chief Nursing Officer shall oversee the development of a policy prohibiting use of forced warm air devices for all pediatric patients outside of the operating room. Formal approval of this policy by the Children's Hospital Integrated Council occurred on July 5, 2017.	

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MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: **135101**	**500 UNIVERSITY DRIVE** **P.O. BOX 850** **HERSHEY, PA 17033**

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A 1104	Continued from page 51 Based on a review of facility policy, medical records (MR), manufacturer guidelines, and staff interviews (EMP) it was determined the facility failed to ensure their policy related to Bair Hugger warming device matched the manufacturer guidelines. Findings include: A review of facility policy "Children's Hospital Standard of Care" effective December 2016, revealed, "...f. Ongoing patient assessment includes the following: Vital Signs...Temperature...For heating/cooling devices: Minimum of every 2 hours when a patient is under a heating lamp, warming blanket, or cooling blanket. If not contraindicated, patients requiring warming/cooling blanket should have continuous temperature monitoring rectal or foley probe in place...." A review on April 12-13, 2017, of MR1 revealed the patient arrived in the Emergency Department on January 10, 2017, at 2:51 PM, with a temperature of 89.4 degrees F, rectally. A Bair Hugger (blanket	A 1104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	390256	A. BLDG: 00 B. WING:	06/26/2017

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A 1104	Continued from page 52 warmer device) was applied to the patient. The following patient temperatures were obtained rectally: 90.8 F at 8:16 PM, 92.8 F at 9:14 PM, 97.8 at 10:44 PM, and 98.0 F at 12:14 AM on January 11, 2017. There were no other temperatures documented until 10:22 AM on January 11, 2017. The patient's rectal temperature at that time was 107.6 F. A review of warming device manufacturer's guidelines revealed, "...Precautions. Monitor the patient's temperature at least every 10-20 minutes, and monitor the patient's vital signs regularly. Reduce air temperature or discontinue therapy when the therapeutic goal is reached or it vital sign instability occurs. ..." An interview conducted on April 13, 2017, at 12:15 PM with EMP26 confirmed the facility did not follow the manufacturer's guidelines, but should have. EMP26 was not aware of the manufacturer guideline regarding monitoring the temperature at least every 10-20 minutes. EMP26 stated, "It was	A 1104		

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A 1104	Continued from page 53 news to me."	A 1104		

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P 0000	INITIAL COMMENT	P 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

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P 0000	Continued from page 1 This report is the result of an unannounced onsite complaint investigation (HBG17I180H) completed on April 12-13, 2017, at Milton S Hershey Medical Center. It was determined that the facility was not in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Hospitals, 28 PA Code, Part IV, Subparts A and B, November 1987, as amended June 1998.	P 0000		

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P 0317		P 0317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 0317	Continued from page 3 103.4 (3) FUNCTIONS (3) Take all reasonable steps to conform to all applicable Federal, State, and local laws and regulations. This REGULATION is not met as evidenced by:	P 0317	1. The Penn State Health Milton Hershey Medical Center (HMC) Chief Medical Officer (CMO) and Chief Quality Officer (CQO), shall email all direct care physicians and advanced practice clinicians a memo regarding this serious patient safety event with reminders about requirements on reporting patient safety events in the patient safety event reporting system. This was completed on April 15, 2017. 2. The HMC Patient Safety Officer (PSO) will institute an electronic health record hard stop alert (an alert that will be triggered when any direct care staff log onto the electronic health record, precluding that staff member from proceeding without acknowledging receipt and review of the alert) indicating the changes to the relevant standards of care and requiring active acknowledgement by the staff member of the message regarding event reporting requirements. An initial compliance report will be generated demonstrating acknowledgement of	Completion Date: **07/24/2017** Status: **APPROVED** Date: **07/14/2017**

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P 0317	Continued from page 4	P 0317	this alert within 30 days by direct care staff employed at the time of survey. The electronic health record hard stop alert will remain in effect for four months for all direct care staff that access the electronic health record system for the first time after April 14, 2017. This was initiated on April 14, 2017. This reporting requirement message will be sustained in new employee orientation and annual safety training in the fiscal year 2018 curriculum. 3. The HMC Chief Nursing Officer will email all nursing staff information regarding this serious patient safety event with reminders about requirements on reporting patient safety events in the patient safety event reporting system. This was completed on April 13, 2017. 4. The PSO will read the HMC CMO and CQO memo regarding this serious patient safety event with reminders about requirements on reporting patient safety events in the	

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P 0317	Continued from page 5	P 0317	patient safety event reporting system at the Daily Safety Briefing. This was announced on April 14, 2017, at 11am. 5. The PSO will oversee the individual counseling and review of the patient safety event reporting for the involved eight clinicians. An attendance roster for the education sessions will document and be attached to the patient safety event report file. All counseling was completed and documented by April 21, 2017 briefing. 6. In order to educate all HMC employees, the PSO will assign to all HMC employees a required Compass learning course (HMC's internal electronic staff education platform) to be completed within 30 days, with content describing timely reporting of patient safety events, HMC expectations of Patient Safety Event Reporting, the methods to report, and references to the Patient Safety Event Reporting policy A09 HAM. Course completion will be tracked in	

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P 0317	Continued from page 6	P 0317	the Compass electronic system. Failure to complete this required course will result in the application of the Progressive Discipline Policy. The training was made available on April 21, 2017. 7. A new Patient Safety departmental policy will be implemented by July 17, 2017 to clearly outline timelines for event reporting into PA-PSRS containing key steps to ensure timely reporting. Escalation to the PSO will occur for delays in review and investigation. The investigation and overall review of events along with an initial consideration for PA-PSRS designation will occur no later than 14 days of initiating the review. Reasons for extension beyond 14 days will be documented in our internal event reporting system by the PSO. After 14 days, if questions still exist regarding the event designation but the event is considered at least an "Incident," the event will be entered into PA-PSRS as an "Incident" until	

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P 0317	Continued from page 7	P 0317	further confirmation occurs. Any time during the 14 day internal review, if an event is confirmed, the report will be entered into the PA-PSRS portal within 24 hours as per current policy. This process will ensure the report is routed appropriately to the Pennsylvania DOH and/or the PA Patient Safety Authority as applicable. This policy will be implemented July 17, 2017. 8. The PSO and CQO will monitor for compliance with regard to timely PA-PSRS reporting and make available, monthly, a report outlining timespans between event date, internal reporting date, and PA-PSRS reporting date to the Patient Safety Committee. This reporting will begin on July 24, 2017. 9. We will continue engagement with our patient safety organization (ECRI) to assist in providing institutional resources, including staff education, that will promote a culture of safety. Additionally, we contracted with Healthcare	

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P 0317	Continued from page 8	P 0317	Performance Improvement (HPI) to provide patient safety-related content, and to assist in a comprehensive assessment of our current culture of safety and develop a road map for improvement. Staff education with materials derived from HPI began on June 15, 2017.	

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P 0317	Continued from page 9 Based on review of facility documents, medical records (MR), Department of Health's (Department) database, and staff interview (EMP), it was determined the facility failed to conform to all State laws: Milton S Hershey Medical Center was not in compliance with the following State law: The Medical Care Availability and Reduction of Error Act, 40 P.S. § 1303.101 et seq. § 1303.313 Medical Facility reports and notifications (a) Serious event reports A medical facility shall report the occurrence of a serious event to the department and the authority within 24 hours of the medical facility's confirmation of the occurrence of the serious event. The report to the department and the authority shall be in the form and manner prescribed by the authority in consultation with the department and shall not include the name of any patient or any other identifiable individual information. (b) Incident reports A medical facility shall report the	P 0317		

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P 0317	Continued from page 10 occurrence of an incident to the authority in a form and manner prescribed by the authority and shall not include the name of any patient or any other individual information. (c) Infrastructure failure reports. A medical facility shall report the occurrence of an infrastructure failure to the department within 24 hours of the medical facility's confirmation of the occurrence or discovery of the infrastructure failure. The report to the department shall be in the form and manner prescribed by the department. This is not met as evidenced by: Based on review of facility documents, medical records (MR), Department of Health's (Department) database, and staff interview (EMP), it was determined the facility failed to report a serious event to the Department and the Patient Safety Authority within 24 hours of the occurrence. Findings include:	P 0317		

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P 0317	Continued from page 11 A review on April 13, 2017, of the facility's "Performance Improvement Plan," effective June 2016, revealed "...External reporting...Serious events and infrastructure failures will be reported to the DOH within 24 hours of confirmation of occurrence via the Pennsylvania Patient Safety Reporting System. Serious Events will be reported to the Patient Safety Authority within 24 hours of confirmation of occurrence via the Pennsylvania Patient Safety Reporting System. ..." A review on April 12-13, 2017, of MR1 revealed the patient arrived in the Emergency Department on January 10, 2017, at 2:51 PM, with a temperature of 89.4 degrees F, rectally. A Bair Hugger (blanket warmer device) was applied to the patient. The following patient temperatures were obtained rectally: 90.8 F at 8:16 PM, 92.8 F at 9:14 PM, 97.8 at 10:44 PM, and 98.0 F at 12:14 AM on January 11, 2017. There were no other temperatures documented until 10:22 AM on January 11, 2017. The patient's rectal temperature at that time was 107.6 F. A review of physician	P 0317		

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P 0317	Continued from page 12 inpatient note addendum dated January 13, 2017, revealed "...We came and saw him in ED around 10 AM. There were no vitals and his last temp was around midnight. The nurse during the rounds told us him temp was now 42 C {107.6 F}. We asked about the Bair Hugger and it had been on high all night. ..." The patient was transferred to pediatric intensive care unit (PICU). A review of the discharge summary, revealed, the patient "...arrived to the PICU in shock with ECG changes consisting of QRS widening and ST elevation, worrisome for conduction system impairment in addition to myocardial functional impairment. ...Despite all these measures, QRS degenerated, there are episodes of pulseless ventricular tachycardia superimposed on a baseline of persistent hypotension. ...Hypotension persisted, with chaotic QRS morhphology and unstable hemodynamics despite ongoing resuscitative efforts. He expired at 5:39 PM." A review of the Department's database revealed the facility reported the above incident on March 29, 2017, to the Pennsylvania State Reporting	P 0317		

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P 0317	Continued from page 13 System (PSRS), 77 days after the event. An interview conducted on April 12, 2017, at 11:45 AM with EMP9 confirmed the facility did not report the event until March 29, 2017. EMP9 stated the facility became aware after the Patient Safety Authority sent the facility a letter dated March 3, 2017, regarding the event. EMP9 stated that an employee reported the event anonymously to the Patient Safety Authority. EMP9 confirmed that no one from the facility had entered the event into the facilty's internal reporting system. EMP9 stated that he would have expected multiple reports regarding this event. EMP9 further stated that "Hands down, no questions, it should have been reported right away."	P 0317		

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P 0317	Continued from page 14	P 0317		
P 0382		P 0382		

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P 0382	Continued from page 15 103.36 (b)(2) PERSONNEL RECORDS 103.36(b) (2) Current information relative to periodic work performance evaluations. This REGULATION is not met as evidenced by:	P 0382	1. The Penn State Health Milton S. Hershey Medical Center (HMC) Manager of Scheduling & Staff Deployment (S&SD) shall create a new process for agency nurse evaluations. The Manager of S&SD will create an evaluation tracking log for all agency nurses to be reviewed weekly by the Manager of S&SD or designee. The tracking log will include the name of the agency nurse and the completion date of the evaluation. The agency will also notify the Manager of S&SD that an evaluation is due for the agency nurse six weeks after the nurse's start date. This process for agency nurse evaluations, including the tracking log was initiated on April 14, 2017. The new process was reviewed by the Manager of S&SD, with all nurse managers utilizing agency nursing staff. 2. A new process shall be created to ensure complete agency nurse evaluations. When an agency nurse's six-week evaluation is due, the Manager of S&SD will send an	Completion Date: **07/17/2017** Status: **APPROVED** Date: **07/14/2017**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	390256	A. BLDG: 00 B. WING:	06/26/2017

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P 0382	Continued from page 16	P 0382	electronic communication to the relevant Nurse Manager with a link to the online agency nurse evaluation form. The Nurse Manager shall complete the electronic evaluation within three business days of receipt and respond to the Manager of S&SD that the evaluation has been completed. The Manager of S&SD will ensure that the evaluations are completed by the Nurse Manager within three business days. The Manager of S&SD will then mark the evaluation completed in the evaluation tracking log. This process was initiated on April 14, 2017. If the agency nurse evaluation is not completed within three business days, the Manager of S&SD will notify the Director of Nursing to take action. If issues are identified, actions may include the progressive discipline process, in order to obtain evaluation. This will be implemented on July 17, 2017. 3. The HMC Nurse Managers and the Agency Supervisors will monitor for known performance issues and	

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P 0382	Continued from page 17	P 0382	inform the Manager of S&SD or designee, as appropriate. The Manager of S&SD or designee will investigate and validate any issues with the relevant Nurse Manager. Based on the findings of the investigation, the Manager of S&SD will decide whether to remediate or terminate the agency nurse's contract. This process was implemented on April 14, 2017. 4. The Nurse Manager of S&SD shall educate all of the Nurse Managers, including those not currently utilizing agency nursing staff, on the agency personnel process. This process shall include the agency nurse evaluation. This information was presented to the Nurse Managers at the Clinical Services Management Council on May 18, 2017.	

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P 0382	Continued from page 18 Based on review of facility policy, personnel files (PF), and staff interview (EMP), it was determined the facility failed to ensure periodic work performance evaluations were completed for one of three personnel files reviewed (PF1). Findings include: A review of facility policy "Agency Personnel" effective October 2015, revealed, "...b. {name redacted} Healthcare will send an evaluation form, six weeks after the agency personnel has worked on the unit. Evaluation form will be completed electronically by the Nurse Manager or designee and submitted to {name redacted} Healthcare. Evaluation is kept on file by {name redacted} Healthcare. ..." A review of PF3 on April 12, 2017, revealed the employee was hired on April 19, 2016. There were no evaluations in the personnel file.	P 0382		

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P 0382	Continued from page 19 An interview conducted April 13, 2017, at 9:20 AM with EMP18 confirmed that no evaluations were done for PF3. EMP18 further confirmed that the facility should have done 3 evaluations, at least 6 weeks apart, for PF3.	P 0382		
P 0385		P 0385		

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P 0385	Continued from page 20 103.38 EDUCATION PROGRAMS 103.38 Education programs Orientation and inservice training programs should be provided in order that hospital personnel may maintain their skills and learn new developments in health care. This REGULATION is not met as evidenced by:	P 0385	1. The Penn State Health Milton S. Hershey Medical Center (HMC) Emergency Department (ED) Nurse Manager shall discuss the requirements to complete all ED nursing competency checklists with the involved agency registered nurse (RN). This discussion occurred with the involved agency RN and the competency checklists were completed on April 15, 2017. 2. HMC shall formalize the process to on-board and track all agency RN general and departmental orientation checklists, which will include competencies. The agency RN will be required to complete these competency checklists within 2 weeks of his or her start date. Completed competency checklists will be reviewed and signed by the Clinical Nurse Educator/designee and/or Nurse Manager/designee to signify approval and completion of the agency nurse's orientation. This new process was initiated on April 17, 2017. If an agency nurse's completed competency checklist is not received within 2 weeks of his or	Completion Date: **07/17/2017** Status: **APPROVED** Date: **07/14/2017**

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P 0385	Continued from page 21	P 0385	her start date, that agency nurse will be placed back on orientation on the next scheduled shift and continue on orientation until the checklists are completed and turned into the Clinical Nurse Educator/designee and Nurse Manager/designee. This process will be implemented July 17, 2017. 3. The Nurse Manager of the Float Pool/designee reviewed all agency nurse files for any incomplete items on all HMC Core Competency checklists. If any incomplete competency items were noted, the departmental Nurse Educators/designee assisted these nurses in completing these items. The agency RNs were given one week to complete the checklist. This review was completed on April 17, 2017. 4. For any incomplete checklist items that were identified, the Nurse Manager of the Float Pool/designee contacted individual Nurse Managers and Clinical Nurse Educators to ensure the agency RN completed the missing checklist	

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P 0385	Continued from page 22	P 0385	items within a one week period. The Nurse Managers and Clinical Nurse Educators were contacted, and the completed checklist items were received by the Nurse Manager of the Float Pool by April 21, 2017. 5. The Nurse Manager of S&SD shall educate all of the Nurse Managers, including those not currently utilizing agency nursing staff, on the agency personnel process. This process shall include the agency nurse competency evaluation. Information on the agency personnel process was presented to the Nurse Managers at the Clinical Services Management Council on May 18, 2017.	

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P 0385	Continued from page 23 Based on review of facility documents, personnel file (PF), and staff interview (EMP), it was determined that the facility failed to ensure that the employee received orientation/training on the thermoregulation technique and devices for one of three personnel files reviewed (PF3). Findings include: A review of facility Emergency Department Registered Nurse Core Competency on April 12, 2017, revealed "...Integumentary/Surface Trauma Competency Statement: Demonstrate or verbalized an ability to assess, identify, provide care, manage, and troubleshoot potential or actual life-threatening integumentary/surface trauma emergencies and associated equipment. ...4. Thermoregulation techniques & devices - cooling machine/Bear {sic} hugger." Further review of the competency form revealed, "This form is to be completed within the the alloted hours for orientation at PSHMC."	P 0385		

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P 0385	Continued from page 24 A review of PF3 on April 12, 2017, revealed the Emergency Department Registered Nurse Core Competency was not complete. The Thermoregulation techniques & devices - cooling machine/Bear {sic} hugger was not signed off as completed. Further review of PF3 revealed the employee was hired on April 19, 2016. An interview conducted on April 13, 2017, at 9:30 AM with EMP4 confirmed the nurse core competency was not completed for thermoregulation techniques & devices - cooling machine/Bair Hugger for PF3 and that the employee was hired one year ago.	P 0385		

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P 0385	Continued from page 25	P 0385		
P 0933		P 0933		

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P 0933	Continued from page 26 109.36 NURSING NOTES 109.36 Nursing notes Nursing records and reports which reflect the progress of each patient and the nursing care planned shall be maintained. They shall be pertinent, accurate, and concise so that they contribute to the continuity of patient care. Nursing records and reports shall become part of each patient's medical record. This REGULATION is not met as evidenced by:	P 0933	1. The Penn State Health Milton S. Hershey Medical Center (HMC) Emergency Department (ED) Nurse Manager will discuss with the involved registered nurses (RNs), the need to document all vital signs (temperature, heart rate,pulse, blood pressure and oxygen saturation) as required in Emergency Department Nursing Standard of Care E 8CPMN (revision date April 13, 2017). The Emergency Department Nursing Standard of Care E 8CPMN was revised on April 13, 2017. The involved RN communication was completed on April 14, 2017. The involved RNs acknowledged in writing that they will comply with required vital sign documentation. Documentation was provided demonstrating that each RN reviewed and agreed to an understanding of this revised standard of care on April 14, 2017. 2. The ED Nurse Manager shall communicate via email to all ED nursing staff the revised standard of care E 8CPMN. The ED nursing staff	Completion Date: **04/17/2017** Status: **APPROVED** Date: **07/11/2017**

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P 0933	Continued from page 27	P 0933	will be required to acknowledge their review of the standard of care with their signature captured on a roster. This email was sent on April 13, 2017. 3. The ED Nurse Manager will review the expectations for vital sign documentation in a weekly newsletter that is distributed to ED staff. The newsletter was emailed on April 14, 2017. 4. For a period of three months, the ED Nurse Manager will oversee audits of thirty (30) randomly selected ED medical records per month for appropriate documentation of vital signs as per the revised standard of care E 8CPMN. These monthly audits will include the involved RNs in each monthly audit. The name of the ED nurse who documented vitals in those records will be recorded for audit tracking purposes. This audit process was initiated on April 17, 2017. 5. The ED Nurse Manager will monitor audit results and utilize the Progressive Discipline process to	

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P 0933	Continued from page 28	P 0933	address any findings of noncompliance as needed with identified staff RNs.	

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P 0933	Continued from page 29 Based on review of facility policy, medical record (MR) and staff interview (EMP), it was determined the facility failed to ensure all significant clinical information pertaining to a patient shall be incorporated in the medical record for one of 11 medical records reviewed (MR1). Findings include: A review of facility policy "Children's Hospital Standard of Care" effective December 2016, revealed, "...f. Ongoing patient assessment includes the following: Vital Signs...Temperature...For heating/cooling devices: Minimum of every 2 hours when a patient is under a heating lamp, warming blanket, or cooling blanket. If not contraindicated, patients requiring warming/cooling blanket should have continuous temperature monitoring rectal or foley probe in place...." A review on April 12-13, 2017, of MR1 revealed the patient arrived in the Emergency Department on	P 0933		

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P 0933	Continued from page 30 January 10, 2017, at 2:51 PM, with a temperature of 89.4 degrees F, rectally. A Bair Hugger (blanket warmer device) was applied to the patient. The following patient temperatures were obtained rectally: 90.8 F at 8:16 PM, 92.8 F at 9:14 PM, 97.8 at 10:44 PM, and 98.0 F at 12:14 AM on January 11, 2017. There were no other temperatures documented until 10:22 AM on January 11, 2017. The patient's rectal temperature at that time was 107.6 F. A review of physician inpatient note addendum dated January 13, 2017, revealed "...We came and saw him in ED around 10 AM. There were no vitals and his last temp was around midnight. The nurse during the rounds told us him temp was now 42 C {107.6 F}. We asked about the bair hugger and it had been on high all night. ..." An interview conducted on April 13, 2017, at 9:40 AM with EMP19 confirmed that the temperatures were not documented in the patient's medical record. EMP19 stated "I know I took temps. I was in the room every hour doing eye drops. I must	P 0933		

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P 0933	Continued from page 31 have not documented, I did not have the computer with me. I was probably busy with something else." An interview conducted on April 12, 2017, at 10:45 AM with EMP4 confirmed that no temps were documented for a "10 hour period."	P 0933		
P 1531		P 1531		

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P 1531	Continued from page 32 115.33 (a) ENTRIES 115.33 Entries (a) All significant clinical information pertaining to a patient shall be incorporated in his medical record. This REGULATION is not met as evidenced by:	P 1531	1. The Penn State Health Milton S. Hershey Medical Center (HMC) Emergency Department (ED) Nurse Manager will discuss with the involved registered nurses (RNs), the need to document all vital signs (temperature, heart rate,pulse, blood pressure and oxygen saturation) as required in Emergency Department Nursing Standard of Care E 8CPMN (revision date April 13, 2017). The Emergency Department Nursing Standard of Care E 8CPMN was revised on April 13, 2017. The involved RN communication was completed on April 14, 2017. The involved RNs acknowledged in writing that they will comply with required vital sign documentation. Documentation was provided demonstrating that each RN reviewed and agreed to an understanding of this revised standard of care on April 14, 2017. 2. The ED Nurse Manager shall communicate via email to all ED nursing staff the revised standard of care E 8CPMN. The ED nursing staff	Completion Date: **04/17/2017** Status: **APPROVED** Date: **07/11/2017**

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	390256	A. BLDG: 00 B. WING:	06/26/2017

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P 1531	Continued from page 33	P 1531	will be required to acknowledge their review of the standard of care with their signature captured on a roster. This email was sent on April 13, 2017. 3. The ED Nurse Manager will review the expectations for vital sign documentation in a weekly newsletter that is distributed to ED staff. The newsletter was emailed on April 14, 2017. 4. For a period of three months, the ED Nurse Manager will oversee audits of thirty (30) randomly selected ED medical records per month for appropriate documentation of vital signs as per the revised standard of care E 8CPMN. These monthly audits will include the involved RNs in each monthly audit. The name of the ED nurse who documented vitals in those records will be recorded for audit tracking purposes. This audit process was initiated on April 17, 2017. 5. The ED Nurse Manager will monitor audit results and utilize the Progressive Discipline process to	

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P 1531	Continued from page 34	P 1531	address any findings of noncompliance as needed with identified staff RNs.	

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P 1531	Continued from page 35 Based on review of facility policy, medical record (MR) and staff interview (EMP), it was determined the facility failed to ensure all significant clinical information pertaining to a patient shall be incorporated in the medical record for one of 11 medical records reviewed (MR1). Findings include: A review of facility policy "Children's Hospital Standard of Care" effective December 2016, revealed, "...f. Ongoing patient assessment includes the following: Vital Signs...Temperature...For heating/cooling devices: Minimum of every 2 hours when a patient is under a heating lamp, warming blanket, or cooling blanket. If not contraindicated, patients requiring warming/cooling blanket should have continuous temperature monitoring rectal or foley probe in place...." A review on April 12-13, 2017, of MR1 revealed the patient arrived in the Emergency Department on	P 1531		

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P 1531	Continued from page 36 January 10, 2017, at 2:51 PM, with a temperature of 89.4 degrees F, rectally. A Bair Hugger (blanket warmer device) was applied to the patient. The following patient temperatures were obtained rectally: 90.8 F at 8:16 PM, 92.8 F at 9:14 PM, 97.8 at 10:44 PM, and 98.0 F at 12:14 AM on January 11, 2017. There were no other temperatures documented until 10:22 AM on January 11, 2017. The patient's rectal temperature at that time was 107.6 F. A review of physician inpatient note addendum dated January 13, 2017, revealed "...We came and saw him in ED around 10 AM. There were no vitals and his last temp was around midnight. The nurse during the rounds told us him temp was now 42 C {107.6 F}. We asked about the bair hugger and it had been on high all night. ..." An interview conducted on April 13, 2017, at 9:40 AM with EMP19 confirmed that the temperatures were not documented in the medical record. EMP19 stated "I know I took temps. I was in the room every hour doing eye drops. I must have not	P 1531		

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P 1531	Continued from page 37 documented, I did not have the computer with me. I was probably busy with something else." An interview conducted on April 12, 2017, at 10:45 AM with EMP4 confirmed that no temps were documented for a "10 hour period."	P 1531		
P 1748		P 1748		

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P 1748	Continued from page 38 117.41 (a) EMERGENCY PATIENT CARE 117.41 Emergency patient care (a) Emergency patient care shall be guided by written policies and procedures which delineate the proper administrative and medical procedures and methods to be followed in providing emergency care. These policies and procedures shall be clear and explicit; approved by the medical staff and hospital governing body; reviewed annually, revised as necessary; and dated to indicate the date of the latest review or revision, or both. This REGULATION is not met as evidenced by:	P 1748	1. The HMC Nursing Quality and Safety Program Director will revise the Adult, Children's Hospital, Emergency Department, Peri-anesthesia, and Women's Health standards of care to reflect a consistent temperature monitoring standard for patients being warmed with a warming blanket. The aforementioned standards were revised and on April 13, 2017, they were approved for immediate application. 2. The Nursing Quality and Safety Program Director will facilitate revision of the Adult, Children's Hospital, Emergency Department, and Peri-anesthesia and Women's Health standards of care to be consistent with manufacturer instructions of temperature monitoring every 20 minutes. The revised standards of care shall be communicated to all relevant inpatient nursing and provider staff. The standards were revised on April 13, 2017. The communication to all inpatient nursing and provider staff	Completion Date: **07/05/2017** Status: **APPROVED** Date: **07/14/2017**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 1748	Continued from page 39	P 1748	occurred on April 14, 2017. 3. The Nursing Quality and Safety Program Director shall instruct all Nurse Managers to include communication regarding the newly updated standards of care in their next weekly updates to nursing staff. This was accomplished on April 14, 2017. 4. The device-specific policy B-7: BAIR-HUGGER WARMING THERAPY and CABINET BLANKET GUIDELINES (PACU) will be deleted to eliminate the possibility for differing interpretations of the policy and standards of care. This was completed on April 13, 2017. 5. An electronic health record hard stop alert (an alert that will be triggered when any direct care staff log onto the electronic health record, precluding that staff member from proceeding without acknowledging	

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P 1748	Continued from page 40	P 1748	receipt and review of the alert) indicating the changes to the relevant standards of care will be instituted, requiring active acknowledgment for all direct care staff. A compliance report will be generated to demonstrate acknowledgement of this alert within 30 days by direct care staff employed at the time of survey. The electronic health record hard stop alert will remain in effect for four months, for all direct care staff that access the electronic health record system for the first time after April 14, 2017. This was initiated on April 14, 2017. This reporting requirement message will be sustained in new employee orientation and annual safety training in the fiscal year 2018 curriculum. 6. The Chief Nursing Officer shall oversee the development of a policy prohibiting use of forced warm air devices for all pediatric patients outside of the operating room. Formal approval of this policy by the Children's Hospital Integrated Council occurred on July 5, 2017.	

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P 1748	Continued from page 41 Based on a review of facility policy, medical records (MR), manufacturer guidelines, and staff interviews (EMP) it was determined the facility failed to ensure their policy related to Bair Hugger warming device matched the manufacturer guidelines. Findings include: A review of facility policy "Children's Hospital Standard of Care" effective December 2016, revealed, "...f. Ongoing patient assessment includes the following: Vital Signs...Temperature...For heating/cooling devices: Minimum of every 2 hours when a patient is under a heating lamp, warming blanket, or cooling blanket. If not contraindicated, patients requiring warming/cooling blanket should have continuous temperature monitoring rectal or foley probe in place...." A review on April 12-13, 2017, of MR1 revealed the patient arrived in the Emergency Department on January 10, 2017, at 2:51 PM, with a temperature	P 1748		

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P 1748	Continued from page 42 of 89.4 degrees F, rectally. A Bair Hugger (blanket warmer device) was applied to the patient. The following patient temperatures were obtained rectally: 90.8 F at 8:16 PM, 92.8 F at 9:14 PM, 97.8 at 10:44 PM, and 98.0 F at 12:14 AM on January 11, 2017. There were no other temperatures documented until 10:22 AM on January 11, 2017. The patient's rectal temperature at that time was 107.6 F. A review of warming device manufacturer's guidelines revealed, "...Precautions. Monitor the patient's temperature at least every 10-20 minutes, and monitor the patient's vital signs regularly. Reduce air temperature or discontinue therapy when the therapeutic goal is reached or it vital sign instability occurs. ..." An interview conducted on April 13, 2017, at 12:15 PM with EMP26 confirmed the facility did not follow the manufacturer's guidelines, but should have. EMP26 was not aware of the manufacturer guideline regarding monitoring the temperature at	P 1748		

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P 1748	Continued from page 43 least every 10-20 minutes. EMP26 stated, "It was news to me."	P 1748		

Certified End Page

MILTON S. HERSHEY MEDICAL CENTER, THE

STATE LICENSE NUMBER: 135101

SURVEY EXIT DATE: 06/26/2017

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Shannon M. Baker

Shannon M. Baker
Acting Deputy Secretary for Quality Assurance

Rachel L. Levine, MD
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

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